Healthcare Information Division

Healthcare Outcomes Center
400 R. Street, Room 250
Sacramento, California 95811
(916) 326-3861
Fax (916) 445-7534

CALIFORNIA CABG OUTCOMES REPORTING PROGRAM
Healthcare Information Division

HOSPITAL CEO DESIGNEE FORM

I, _____, certify that I am the
Name of CEO or ADMINISTRATOR

CEO/ADMINISTRATOR of _____
Print: Name of Hospital

The following person(s) is authorized to sign, on my behalf, the CCORP Hospital Certification Form (OSH-CCORP 416).

Designee Name, Title and Signature

_____

_____

_____

CEO/Administrator Name: _____

CEO/Administrator Signature: _____

Date signed: _____

RETURN THIS FORM BY FAX TO: Denise L. O'Neill, CCORP Data Manager
Ph: 916.326.3865
Fax: 916.445.7534